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AUTHOR Rebelsky, Freda
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ABSTRACT

This project is a prototype study which investigates the interaction of graduate students from different disciplinary backgrounds and different educational institutions in exploring social and public policy issues related to children. The results and evaluation of the research program are presented in this document. Divided into three teams, the students examined three social issues in relation to child development: (1) legal problems of providing medical care to minors; (2) treatment of children in state mental health facilities; and (3) advocacy and lobbying for children. Three reports from these student teams follow the explanation of the study. The report concludes that small and delimited research projects can profitably and successfully be completed by small teams of graduate students provided that the scope of the research is carefully delineated and established in advance, the groups are small and the tasks well structured, and the projects are closely supervised by staff. (Author/JR)

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Student Surveys of Policy Issues Related to Children

by

Freda Rebelsky

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Center for Law and Health Sciences
Boston University School of Law

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Student Surveys of Policy Issues Related to Children

Final Report and Evaluation

I. Background

In the summer of 1972 the Center for Law and Health Sciences received funding from the Office of Child Development to support a demonstration project in which graduate students from different disciplinary backgrounds and different educational institutions would explore social and public policy issues related to children. The students did field work research on three topics: 1) legal problems of providing medical care to minors, 2) treatment of children in state mental health facilities, and 3) advocacy and lobbying for children.

As initially conceived, this project was to be a prototype study to investigate the interaction of students in small-scale surveys and research projects from which recommendations, position papers, and public policy suggestions could be developed. An additional objective of the study was to involve students in the process of interdisciplinary education. It was hypothesized that practical field work and exposure to students of different academic backgrounds would broaden and enrich the graduate education of the participants. Also, the students would learn to incorporate legal, ethical, and social values in reaching a broader understanding of the social and public policy issues related to child development. The students would undertake empirical research and the investigation of actual practices in the Boston community, as well as background library study. They were to be supervised in their work by faculty advisers and staff members of the Center for Law and Health Sciences.

II. Team Projects

Twelve students participated in the summer project. Included were two undergraduates who were sponsored by the M.I.T. Urban Legal Studies Program. There was a team of students to investigate the legal problems of providing medical care to minors. They were: a third-year law student from Boston University, a third-year medical student from Emory University, and an undergraduate from the Massachusetts Institute of Technology.

Five students were working as a team to study the treatment of children in state mental health facilities. These students included three Boston University students from the disciplines of psychology, philosophy, and law; one student from the Urban Planning Department at M.I.T.; and one undergraduate from Wellesley College. The four members of the team working on the topic of advocacy and lobbying for children included two Harvard law students, a psychology student from Boston University, and a student in the department of education from Antioch College.

Each student team began its project with an exploration of the relevant literature and discussions with people who are expert in their fields. The teams were given freedom to define the issues on which they would concentrate and to delineate their own method of approach. As a result, the students spent a great deal of time deciding on those goals which they might reasonably achieve within the nine-week period. The rate of progress of the research projects varied according to the cohesiveness of each group, the scope of the topic selected, and the accessibility of information.

A. Team Project on Legal Problems of Providing Medical Care to Minors

The three student members of this team set out to ascertain the legal disabilities of minors in obtaining medical care. They questioned whether or not physicians are aware of the legal status of minors in regard to medical care and if a doctor's concept of the law affects his decisions about treating adolescents. The students undertook a detailed survey of the state of the law in regard to the rights of minors to consent to their own medical care, and they planned to discuss with knowledgeable professionals the need for new legislation in this area. In order to ascertain physicians' attitudes and practices regarding treatment of minors without their parents' consent, the students hoped to complete an extensive survey of doctors in different medical specialties. Their goal was a statistically significant survey of physicians in private practice, in hospital practice, and in group and clinical work.

During the course of their project students realized that it was too ambitious to complete during the limited period. Because of this, they restricted their survey to private practitioners in the Boston area. Beyond this alteration of their plans, though, this team was quite successful in achieving their goals. Their report (attached) is largely a survey of the state of the law and a realistic appraisal of the liabilities facing a physician who treats a minor without parental consent. The students are still in the process of doing a statistical analysis of the responses to their survey. They had also prepared questionaires to be distributed to doctors in hospitals and in clinical practice. This part of the survey could not be completed within the time limit assigned.

B. Team on Treatment of Children in State Mental Health Facilities

The students of this team also spent considerable time defining the objectives of their project. Whereas some team members hoped to do a comprehensive survey of all state institutions for children, others felt that this goal was beyond their capabilities and time limitations. The students were somewhat reluctant to evaluate and make qualitative judgments about the medical care provided to children in Massachusetts. They resolved their dilemma by deciding to limit their project to a careful study of the facilities currently available to emotionally disturbed children in a section of Boston. Concentrating on one Boston community, Allston-Brighton, the group analysed the availability of mental health services from two vantage points. Three members of the group explored the administrative structure of the system, interviewing and speaking with state mental health officials, directors, physicians, and other members of the staffs of relevant facilities. The other two students approached the system from the point of view of a consumer, that is, as a parent who is seeking help for an emotionally disturbed child in this area. These team members sought out facilities primarily through those sources most available to such a person, for example, help lines, church groups, and local hospitals. The result of their survey is the attached paper, a kind of handbook directed toward parents in Allston-Brighton who need support services for their children. The report specifies the types of cases which can be treated, the means of access to local institutions, and notes the usual fees and length of waiting periods.

The team hoped to include a statement of the legal rights of emotionally disturbed children but they decided that this was too complex

for a simple factual pamphlet. The students would like to reproduce the pamphlet in a simple and inexpensive form in order to distribute it throughout the community.

C. Team on Advocacy and Lobbying for Children

The four student members of this team attempted to grapple with the many meanings of the team "child advocacy" as it is used by government agencies, special projects, and professionals who work with children. They began their project by contacting individuals and groups who are seeking to increase and improve the facilities and services available for children. They spoke to members of the 4-C's Council, the Massachusetts Childrens' Lobby, and the Office of Child Development. The team members also contacted Massachusetts legislators who are involved with the passage of several bills relating to children.

This team had some difficulty defining its goals because of the ambiguity of the term "child advocacy." The students began by designing their own model of a child advocacy project. This advocacy center was to be a community-based referral system for children with a variety of needs -- medical, social, legal, and educational. The Center would not provide these services directly but would rather refer children to the appropriate facilities. In addition, in the case of administrative resistance to the admission of children to these institutions or facilities, the advocates would use legal skills to press the childrens' rights to treatment.

In order to test the usefulness of this model in given communities, the team members selected four areas of Boston with different ethnic and economic characteristics. The group felt that in this way they would get a clearer idea of how their advocacy program might apply across the

entire country. The students visited administrators and staff of agencies, legal aid offices, drop-in centers, health centers, guidance clinics, schools and charities in Cambridge, Somerville, East Boston, and Newton. They also visited and met with the entire staff of a model child advocacy project in Dorchester.

The group decided, as a result of this field work, that their model could not be successfully used in all of these communities. Rather, while it might work in a situation where adequate facilities other than the child advocacy project function, it would probably not be successful in areas of the city where independent resources were lacking.

After this decision, the team re-evaluated their goals and attempted to formulate a new definition of child advocacy. One team member visited Washington, D.C. and met with people who are working at the national level on child advocacy programs. The students eventually produced a report which explores the many definitions of the term "child advocacy." They agreed that a comprehensive definition which included all of the projects operating under this rubric was unwieldy and confusing, and they decided to outline several uses of the term, and to suggest a concept of child advocacy based upon a legal model. While in general these students were somewhat disappointed by their inability to reach a comprehensive definition of child advocacy, their careful delineation of the confusion inherent in this concept and their recommendation of a useful approach are embodied in a report which may be of use to policy-makers and professionals as well as laymen working in related fields of child care services.

III. Evaluation of Program

A critical evaluation of this summer program yields several con-

clusions as to the appropriateness of engaging graduate student teams in public policy research. In general, small and delimited research projects can profitably and successfully be completed by small teams of graduate students. The most important characteristics for the success of these teams are:

1) The scope of the research must be carefully delineated and established in advance. It is difficult for a team of students, during a short period of time, to set forth realistic goals for themselves. Important time may be lost debating and questioning the proper goals of the project. Theoretical issues are inappropriate for use by these groups; there is not enough time to develop and debate them properly. On the other hand, graduate students are often ideally suited for research into concrete and nontheoretical issues, involving data collection, interviewing, and field work. For example, students may gain access to government officials or institutional administrators who would feel threatened by more professional interviewers, and students may be very persistent in interviewing, or collecting data.

The success of student field research was demonstrated by the team which worked on legal problems of providing medical care to minors. They designed and carried out their survey of physicians in the Boston area, first consulting medical directories and other sources for lists, dividing the lists into categories of specialties, and selecting the individuals for interviews. The team contacted those physicians, met with them, and left the survey form with them. They followed up with telephone calls, and persevered until most of the physicians had completed the questionnaires.

2) An essential characteristic to the success of student research teams is that the groups be small and the tasks be well structured. A larger group may tend to fragment and, as a result, will be less directed toward a unified goal. The presence of a predetermined structure with a clear assignment of tasks can mitigate many problems. If the students are told what each must do and how to work together, the goals are more likely to be accomplished.

3) Another factor that is necessary for the success of these teams is close supervision by the staff. Often students become discouraged when problems interfere with their objectives, and they need regular, consistent, adult guidance in order to achieve their stated goals. The presence of an experienced teacher and researcher who is aware of problems of group dynamics, and sophisticated about such issues in team programs can be greatly helpful. The faculty supervisor should help to define and describe substantive issues as well as giving them suggestions about persons to contact. Discussions and practice in conducting interviews and surveys are often necessary.

In addition, the adviser should underscore and explain to students the importance of the research process in achieving a substantive result and as a learning experience. A student should feel that his project is worthwhile.

IV. Conclusions

All of the three student teams did well. The team with the fewest members and who had the most carefully delineated and structured topic produced the most positive results. The other two teams found it difficult to set realistic goals. Once, however, they had decided upon

limited objectives which might reasonably be achieved during the allotted time period, they reached their goals.

The students' evaluation of their experiences varied also. Most team members had positive feelings, citing the importance of a self-directed, educational experience outside of the regular academic context. Others did not perceive the research program as a learning experience, because no formal academic program was involved. However, even these students noted that the program provided insight into the workings of the governmental process and an awareness, as with the child advocacy model, of the difficulty of incorporating theoretical concepts into workable projects. Students also noted that thesis topics and new career goals turned up during the projects.

After reviewing the progress of the summer program, we believe that there is great potential for education and research for student groups who are working on public policy issues. They should be given a well-defined topic and a carefully structured research program based on data gathering, surveying, and interviewing and research projects which can be worked on within a short period of time. It must be noted, however, that professional guidance is essential to the successful conclusion of these projects.

The three reports from these student teams are attached. Generally they are indeed noteworthy accomplishments, and their publication should be arranged, where appropriate. Because it is our overall conclusion that the summer program was a success, we hope to offer an expanded program of similar research projects for graduate students in the future.

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Title of Project: Student Surveys of Policy Issues Related to Children

Principal Investigator: Freda Rebelsky

CHILD ADVOCACY: A NEW CONCEPT

Center for Law and Health Sciences
Boston University School of Law
Summer, 1972

CHILD ADVOCACY: A NEW CONCEPT

Introduction

This paper grew out of the work of one of several summer study teams set up and sponsored by the Center for Law and Health Sciences, under a grant from the Office of Child Development (OCD) of the Department of Health, Education, and Welfare. The team was made up of graduate students from different academic disciplines; two members were training for careers in law, another for a career in psychology, and one was a student in the department of education. It was felt that the project would demonstrate the value of short-term, problem-centered, interdisciplinary research.

It was difficult to verify the value of this approach, because the group encountered several difficulties in its work. For one, the topic proved to be so broad that it did not lend itself to the short-term, concentrated attack that was originally envisioned; for another, the complexity of the task may have exceeded the capabilities of a group with professional training but no professional experience.

Possibly as a result, the focus of the group's work was rarely fixed, at least for long. Our approach was often controlled by the amorphous nature of the concept of child advocacy. The decision to keep the focus general throughout the entire project was also dictated by the fact that we were limited, for the most part,

to working in the local area, a far geographical distance from most of the child advocacy demonstration projects currently in progress.

This article remains broad and impressionistic, and should perhaps be read as an essay. Many conclusions are not supported by data because no data were available; we hasten to say that we are by no means apologetic for what often amounts to no more than educated suspicion.

One of the problems in this area is that of definitions. The concept of child advocacy is something entirely apart from the direct provision of services which we now know. We often found that the services were ineptly provided, from overlapping jurisdictions, with bureaucratic tie-ups, unnecessary red tape, slowness, and lack of energy and foresight.

Advocacy, as we have described in this paper, is a tool by which individuals change the system and the system changes itself. It is a watchdog activity, an administrative function with nothing to administer. Given the many needs that exist, it is not easy to justify a middle layer which neither provides services nor administers their provision. To make the concept acceptable, people, especially service providers and decision-makers, must be convinced of its broader utility to the processes of provision and administration.

A child advocate might deal with many problem areas. Children of divorced parents, children involved in difficult custody cases, abandoned or battered children, adoption cases, step children, child laborers, or migrant workers, children with medical, educational, or emotional problems, all obviously need help and a strong advocate in order that they may not become the pawns of warring or exploiting adults or systems. We do not feel that "warring" is too strong a term.

We wish to emphasize the in-and-out role of the advocate. He does not become the guardian of the child in a divorce case, nor represent him in court except perhaps in an emergency; rather he applies pressure to the Division of Child Guardianship, to the legal aid offices and bar associations, to the hospital administrator, or the Department of Immigration. The advocate does not set up recreation centers in poverty areas; rather he pressures the school department, the OEO, a local university, the city council. The advocate must identify needs, move intelligently to find someone to fill them, and force that process to take place.

Child Advocacy: A New Concept

> ...It means legal counselor, spokesman, supporter, pleader, defender, protagonist, intercessor, proponent, mediator, monitor, petitioner, activator, coordinator, ombudsman, expediter, enabler, promoter, protector, instigator, investigator, and exposer.
>
> -Naomi Hiett, "Advocacy for Children by State Committees on Children and Youth," Advocacy for Children, May, 1972.

"Child advocacy" means many different things to different people. The most common reaction when the term is mentioned remains: "What is it?" a response heard from professionals and laymen alike. Only those who are engaged in activities bearing that title appear to have an idea of what the advocacy function is - and they often would not recognize it in each other.

Child advocacy represents a new rallying cry on behalf of America's children, a group which "child advocates" point out has long been inadequately provided for despite a great deal of rhetoric about children as "the hope of our future." Can the term be more than useful rhetoric? Must it? Some would say that, at a time when the nation seems to be pulling back from efforts to solve major social problems, any means by which those efforts can be promoted is legitimate, even if the new term denotes nothing new in the nature of actual programs. This view appears shortsighted, however, in light of the apparent trends.

There are several problems and issues to be faced when new advocacy projects are being considered on a national, state, or local level. An administrative grouping of advocacy projects with little purpose in common may result if Congress were to authorize a national advocacy system. The creation of a National Center for Child Advocacy could result in bureaucratic confusion and lack of strong, necessary direction from the higher administrative levels.

On the other hand, individual projects, however well designed, could suffer from being fragmented and isolated. Finally, dynamic rhetoric applied to a new program might exacerbate genuine problems by falsely raising the expectations of the public and the clients.

Background

The phrase child advocacy first gained prominence in the report of the Joint Commission on Mental Health of Children in 1969, which recommended that: "Federal funding be provided for the establishment of an advocacy system at every level of society," national, state, local, and neighborhood. Operational details of the recommended National Advisory Council, state Child Development Agencies, local Child Development Authorities, and neighborhood Child Development Councils were not stated clearly in the report. It was stated that they were to be concerned with "planning,

facilitating and coordinating services and with insuring these services to children, youth and their families," and not with the direct provision of services.

The term "child advocacy" was used in several discussion forums of the 1970 White House Conference on Children. The final report of one forum recommended a national advocacy system similar to that called for by the Joint Commission. The forum members envisioned local offices made up of one (or more) full-time Child Advocates and "such additional staff as its needs and funds permit," although the nature of that staff was not defined or described. A Child Advocacy Board composed of representatives of local child-serving institutions and clients would hire the staff, mobilize support for the Advocate's work, identify problems, and forge solutions at the local level. The Advocate himself was seen intervening with agencies and institutions (and, at times, with families) on behalf of individual children. The paths of access to the Advocate were not described.

In 1971 Senator Abraham Ribicoff proposed legislation to set up twenty child advocacy centers in different parts of the country to explore the feasibility of a national system, presumably to reach every neighborhood. The duties of these offices, described in only vague terms, centered around assessments of needs, counseling and referral, planning, and data collection. Active

intervention in current programs was not identified as a goal. This proposal was included as an amendment to the comprehensive child development bill (S. 2007) proposed by Senator Mondale. Several of the more conservative members of the House of Representatives opposed the entire concept, and supporters had difficulty defining, much less defending, child advocacy. A House-Senate conference committee finally dropped the provisions because they were controversial. The legislation as it was eventually passed was vetoed by President Nixon, a fact to take into account when considering the practicalities of various proposed models for advocacy.

In mid-1971 a National Center for Child Advocacy was set up in Washington as part of the Office of Child Development (OCD) in the Department of Health, Education, and Welfare (HEW). With an extremely small staff, the personnel of the Center were primarily concerned with keeping track of various activities, both public and private, that are billed as "child advocacy" projects. The long-range purpose of the Center is unclear. Some officials felt that it should serve as the Federal government's Child Advocate, the top tier of a system similar to that recommended by the Joint Commission, to provide a planning and lobbying voice in Congress and with the public for children at the national level. Reorganization within the Office of Child Development during 1972

has made that role unlikely in the near future. Part of the Children's Bureau, one of the oldest of Federal agencies, the Center now oversees the Division of Vulnerable Children (formerly the Social Services section of the Children's Bureau and not a new service) and the Community Coordinated Child Care program to be discussed below. The sections focus on information-gathering and dissemination; and, although these functions are necessary, they are hardly dynamic advocacy models.

Projects

Although no coordinated advocacy system has been developed at the Federal level, many agencies have initiated demonstration projects to which the label "child advocacy" has been attached.

Five local Community Coordinated Child Care councils, for example, have been funded for child advocacy work. These projects were originally developed as "demonstrations in coordination" and only later were renamed "child advocacy" projects by the research and demonstration component of the Office of Child Development as that term gained popularity with the public and Congress. There appears to be little to distinguish those five projects from the other 4-C's, all of which are involved with coordination of operations and planning by local service-providing agencies. Whereas pamphlets printed about the 4-C have described it as a "link between clients and agencies," that link takes form in the required

one-third representation of "consumers" on each 4-C council. Such representation is not designed to serve the individual needs of clients in the future.

Seven of the thirty-three Head Start Parent-Child Centers (PCC) have been given additional Federal funds to support a child advocacy component. This has largely meant an expansion of the coverage given the PCC's local catchment area through a program of door-to-door efforts in search of families with very young children. In addition to the child development, nutritional, and psychological services provided directly by the Parent-Child Center, the advocacy groups have attempted to identify problems and provide referral to other direct service-providers within the community. For example, barriers to access to the proper resources have been broken with such techniques as accompanying mothers for clinic visits and helping them to deal with long, detailed and confusing application forms. The forms are now available in advance at the Parent-Child Center.

The PCC's have been less successful at effecting significant policy changes in local agencies, and at forcing the development of new services than some people in child oriented organizations had envisioned. This is partly due to inadequate funding and partly to political constraints from the national level.

In 1971 the Office of Education's Bureau for the Handicapped (BEH) and the National Institute of Mental Health (NIMH) jointly funded six projects which covered the spectrum of what has been called child advocacy. Some were attempting to identify problems and outline plans, others practiced direct intervention on behalf of individual children and contemplated "lay[ing] the base for appropriate institutional change." As might be predicted, those working in the latter direction provoked considerable local controversy.

The statement from BEH/NIMH announcing these grants noted that basic legal rights of children generally had not been fulfilled, though they had often been established by state statutes. However, BEH/NIMH does not appear to have stressed this goal in the actual work of its advocacy projects. Further, five additional grants for 1972, in which the Social and Rehabilitation Service (SRS) of HEW has joined, will be administered by established agencies, and they will probably lack the community base of some of the 1971 projects.

SRS alone has funded a single project through its Rehabilitation Services Administration: the Center on Human Policy, at Syracuse University. Their direct goal is based on the belief that the mentally and physically handicapped should not be isolated in special institutions, and the Center attempts to establish the rights of these children through pilot programs and to develop

viable alternatives to institutionalization. Court action has been used, for example, to establish the right of the retarded child to special education within the public school system. The Center has prepared model legislation and has presented testimony at legislative hearings. Pilot programs such as those establishing halfway houses have been developed through negotiation with traditional service providers. Individual parents of retarded children who call or are referred are aided in their efforts to secure services; however, it should be added that individual casework is not considered the major function of the Center.

Another single project has been funded by the Legal Services division of the Office of Economic Opportunity (OEO). The Center for the Study of Student Citizenship, Rights, and Responsibilities in Dayton, Ohio, is less a research center, as its name might suggest, than an experiment in direct intervention. The Center focuses primarily on the legal rights of youth as they relate to the school system and the police, and it is based chiefly in the black community of Dayton. The Center's activities include a program to educate students and institutional personnel about statutory and constitutional rights of minors. A close relationship with the school department aims at providing an orderly system to negotiate school-student conflicts, legal action to establish certain rights, and direct crisis intervention. The

activist nature of this and the Syracuse project contrasts with the projects described earlier. It should be noted that both the last projects were independently designed before a source of funds was available; neither was part of a coordinated demonstration program with goals and guidelines set in advance by the funding agency.

In addition to several other groups of federal projects which have been given the advocacy label, many state, local, and private agencies have picked up the term and used it in various ways. The Michigan Department of Social Services, the state agency which administers public assistance and child welfare programs, has used the term to describe an internal complaint and appeal mechanism to be used by departmental staff members. The Cambridge and Somerville Legal Services agency (Massachusetts) has applied the term to a new subdivision that has been proposed to deal with the whole range of potential legal problems of minors. Child and Family Services of New Hampshire have developed a family advocacy program to bring about institutional change through legislative and administrative lobbying.

Proposals

The proliferation of child advocacy projects has made clear the need for a concise definition. Secretary Richardson, of the Department of Health, Education, and Welfare, has requested a

report, and an Interagency Committee on Child Advocacy, including representatives of all the bureaus which fund advocacy projects, has been given responsibility for this. The Office of Child Development has funded a "baseline study" of the topic by Alfred Kahn of the Columbia University School of Social Work. In addition, a smaller study is being conducted by the Washington Research Project, a private policy research group; and the Boston University Center for Law and Health Sciences assigned one of its OCD-funded summer study teams to the topic, and this paper is the result, as we have noted in our introduction.

Before describing what child advocacy is or might be, it is necessary to define some things that it is not. A child advocacy program might include some or all of these nots, but they alone should neither separately nor collectively be considered to be a definition of child advocacy. Let us begin by noting that child advocacy is not that process of gathering facts, evaluating programs, identifying needs, and setting priorities, long more accurately called planning. Second, child advocacy is not the processes of surveying resources and avoiding duplication better described as coordination. Although communities often lack accurate, available information on which services may be obtained, where, and how, the provision of information is not in itself child advocacy. Conversely, neither should seeking clients or publicizing services be called child advocacy; rather those

functions should be known by specific names such as case-finding and public relations.

Child advocacy could more accurately be called a process by which institutional change is brought about in the interests of children. The first problem which child advocacy must deal with is that of children's access to help. As noted above, a child advocate is not merely an information clearinghouse; referral work should be called just that, though an advocate may do it. However, barriers to access to the proper agency often exist, and bridging them involves what might be called vigorous referral, a part of the advocacy function. These barriers may be enmeshed in red tape, bureaucratic sluggishness, mistaken interpretation of legally defined roles, or, at times, incompetence, prejudice, or corruption. Where services exist, if only on paper, the child advocate should work to make them available to those who need them. This work might include suggestion, persuasion, and cajoling, and should extend also to actual litigation, application of pressure from other governmental quarters, and, if necessary, direct public protest action.

Such vigorous referral work will generally be done on behalf of individual children and their families. The legal connotations of advocacy as a one-to-one process of representation should not be abandoned. Child advocacy should aim at changing institutional policies; thus, for example, a waiver of needlessly complex

application procedures should not be considered an adequate response when a deeper reformation of the procedure is needed. Similarly, an agency's agreement to provide services in a particular case through such mechanisms as mislabelling problems (for example, when an emotionally disturbed child is classified as retarded) is not adequate when all such cases should be within their jurisdiction.

Access is the beginning of the advocacy function. Children and their families may require action on their behalf at every step in the process by which services are provided, and the advocacy function includes monitoring policy at every stage. The work might involve the establishment, in connection with service-providing agencies, of regular procedures for consideration of complaints and negotiation of solutions. A congenial working relationship with agencies should be sought and maintained, but a child advocacy unit should remain willing to take a more adversarial stance when it is deemed necessary. It should, in fact, have legal standing to bring suit in its own name when it is difficult or awkward to get consumer plaintiffs. It is especially important to this policy-monitoring function that child advocacy have legitimacy in order to become an effective force to deal with established institutions.

Another function which has often been called advocacy is legislative lobbying. Lobbying for children is a process which differs little from lobbying for or against gun control, sugar

quotas, or oil depletion allowances. There seems little reason to call lobbying by any other name, and it is clear that this function is crucial to the process of change which is a major goal of child advocacy. Persuasion, administrative lobbying, and court action cannot bring about all the policy changes that are necessary and desirable; in fact, these methods are probably least effective when applied to some of the most important changes.

Groups who lobby for children have appeared for the first time during the last two years. A National Children's Lobby focuses its attention on the United States Congress, and various state counterparts have begun to function. Where such groups exist, a close working relationship with the system of local child advocacy offices would be very helpful. Where there is no such group, or where it does not function efficiently and vigorously, a child advocacy system should develop its own lobbying capability at state and local levels. The main reason for separating legislative lobbying from the other advocacy functions is the different nature of the work. Lobbying involves the establishment of a vast network of concerned citizens to write letters and make telephone calls, the close, day-to-day following of bills as they make their slow way through the legislative process, and the effective utilization of that network at crucial points in the process.

An advocacy system with its direct client contact would be an ideal means for identifying policy obstacles that face individuals. Thus planning, though not advocacy, becomes, like legislative lobbying, a necessary and helpful adjunct. The planning functions can be facilitated by an office with statewide responsibilities. A Resource Bureau might serve local child advocacy offices in the same manner that legal services offices are served by a state-wide law reform institute. The bureau would work closely with the local offices, drafting legislation and proposed organizational changes for agencies and administrators, conducting feasibility studies to be used for administrative lobbying, compiling statistics, surveying state and local law to identify poorly utilized rights to services, preparing briefs for court cases at the local or state level, and generally doing research at the request of local offices. Such a bureau might perhaps be funded as an independent center within a university, thus enabling it to draw upon additional professional expertise easily.

Problems

The establishment of any sort of child advocacy system raises a series of problems and issues which require difficult choices to be made. One of the important issues is the independence of such a system. It has been suggested that an advocacy system could be administered by existing public or private agencies.

This arrangement would have the advantage of immediate legitimacy from the parent agency and could make a major contribution to that agency's efficiency and referral capability. However, because of the often contradictory and adversarial nature of the advocacy process, it is essential that child advocates be free from the control of direct service providers. For the same reasons, it seems advisable that advocacy centers endeavor to provide only short-term emergency services when absolutely necessary.

Related to the issue of operational and structural independence is that of funding. Federal funds are probably more appropriate than state and local monies. Also, currently more services are directly provided to children by state and local agencies than by Federal programs, and they perhaps need somewhat less prodding than their state and local counterparts. For these reasons, it seems preferable to fund a child advocacy system with Federal money.

Although independent of direct service providers, an advocacy system will deal with them frequently. Therefore, for most purposes, a congenial working relationship is desirable, one which encourages solutions without resort to court action, pressure from outside sources, and so on.

The nature of the staff of a child advocacy group is very important. Much of the adversarial work of a local office

requires legal expertise; a staff attorney is mandatory. To what extent should other professionals be involved: social workers, clinical psychologists, public health workers? Should an advocacy center develop a comprehensive diagnostic center, or does this border on the direct provision of services? To what extent can personnel be trained as paraprofessionals to do the institutional advocacy work of a center? Who should be called a child advocate?

Finally, what is the role of leadership and personality in the operation of an advocacy center? The design and operation of two of the most apparently successful demonstration projects in child advocacy, the SRS project in Syracuse, New York, and the OEO project in Dayton, Ohio, are influenced at every point by the leading hand of one person. Is such leadership necessary for success? What training is necessary? Can it be replicated? What of the personal qualities of other staff members? In selecting non-professionals from the local community, it may become apparent that some individuals, though lacking in formal training, have shown skills for this type of work. Universities might study the qualities necessary for child advocacy and begin to develop training programs; Federal grants for such research should be made available.

A brief survey of several Boston-area communities of different sizes, social class composition, race and ethnic group,

and institutional resources led to the conclusion that the nature of the advocacy function might vary considerably from one community to another. Major cities often have a poverty area within which most experimental social programs are focused. Those programs may be inefficient, may overlap and breed competition, and may leave major gaps which are less visible because of the general appearance of action. Other areas - parts of cities or regions of states - may be almost completely without services because of geographical and physical isolation or historical underrepresentation. In some communities, the predominance of one social class may obscure the problems of another; for example, a generally affluent suburb, well provided with private, fee-collecting service institutions, might at the same time include less affluent or poor citizens whose needs are not met. Political conflict among service-providing agencies or between agencies and state and local government may produce such a standstill that advocacy work is essential in some communities. On the other hand, when conflict is severe, it may be almost impossible to establish an independent agency which is itself able to stay free from those conflicts.

Such variations and factors will affect the type of advocacy program most relevant in a particular area, and will determine operating methods as well as the balance between access-centered activity and policy monitoring. Imposing rigid guidelines as to

function or staff on local offices could severely limit their abilities. Rather, the nature of local centers must be determined by the needs of the community to be served. Not only should staff members be drawn from these communities when possible, but efforts should be made to involve citizens in the planning and current work of the local office. Service-providing agencies and local government officials should also be involved; however, they obviously cannot control design and operation.

As the number of problems unique to adolescents has increased, many service providers have begun to distinguish between children and youth, a distinction which might be useful for local offices. Some areas might be served by an advocacy unit dealing with only one of the two, separate offices might be established, or efficiency might dictate the development of separate divisions within one office. For example, the Syracuse project is concerned exclusively with the developmentally handicapped. A limited office has a wider geographical catchment area because of fewer potential clients in the general population. Indeed, the community issues we have noted would rarely be relevant because there would be no "community" to be served in the cohesive, residential sense. Specialized child advocacy offices might receive referrals from local offices as well as from more direct sources. Both types of offices could be linked to the statewide Resource Bureau.

What are some of the paths of access to a child advocacy office? Certainly such an office would handle referrals from direct service providers. Some agencies lack the capability for knowledgeable referral work when they are dealing with multiproblem children and families. Further, they are often unable or unwilling to take positions that are antagonistic to other agencies when their clients are known to be having unsatisfactory experiences somewhere along the line. This is exactly where the child advocate should be most effective. A door-to-door canvassing program should also bring the advocate's services to those not likely to be reached otherwise, and in addition, wide publicity should advertise the advocate's availability on an informal, walk-in basis.

A wide access net brings with it additional problems. Although the system described in this essay is referred to as "child advocacy," it also deserves the name "family advocacy." Agencies which deal with children are the primary focus for intervention and institutional change, but the child advocate will obviously deal at times with situations of intrafamily conflict, when older children or those seeking help alone present themselves. Although it is not the advocate's job to intervene with a family, it is his obligation to secure help for the child, even when this brings him into what appears to be conflict with the wishes of the family. It is necessary for the Resource Bureau to

conduct a comprehensive study of state consent laws and provisions for guardianship, working with lobbying groups to make any needed changes legislatively in order to deal effectively with such situations. The maintenance of the family should be a primary goal in each case.

"Child advocacy" as it has been sketched in these pages can be an important new approach to fulfilling the needs of children, rather than an empty bureaucratic phrase. However, we must add that the political implications and practicality of a program should be considered by anyone who proposes it. The unfortunate fate of vigorous, often adversarial programs like the OEO Legal Services and VISTA should be remembered. We should also remember that a watered down and weak program is at times of less value than no program at all. In light of the current national Administration's philosophy of social policy and federalism, the prospect of federal funding for a vigorous, boat-rocking child advocacy system to marshal demands for new services and policies at the national, state, and local levels is hardly propitious.

Grant Number: OCD-CB-431

Title of Project: Student Surveys of Policy Issues Related to Children

Principal Investigator: Freda Rebelsky

MENTAL HEALTH FACILITIES FOR CHILDREN IN MASSACHUSETTS

Center for Law and Health Sciences
Boston University School of Law
Summer, 1972

MENTAL HEALTH FACILITIES FOR CHILDREN IN MASSACHUSETTS

Description of Project

For the first two weeks of the summer program, our group immersed itself in mental health literature to get an overview of the field and to help us decide what direction we would pursue over the summer. Certain that we wanted to accomplish something useful as a result of our study of mental health care of children, we finally decided on developing a handbook for parents of Allston/Brighton telling them of facilities, services and programs available for treating emotionally disturbed children between ages 5 to 15, and how to navigate themselves through the system. More specifically, we envisioned the handbook to provide parents with a description of what exists in their community (and in Greater Boston); how best to avail themselves of these services; and what to anticipate when making contact with various points in the mental health system.

Based on our belief that there exists different perceptions of reality in terms of what a service says it provides and what it actually does provide, we decided to divide our team into upper level and lower level groups to test our hypothesis. The "upper level" people interviewed over 40 individuals in agencies and institutions who provided some service for Allston/Brighton's emotionally disturbed children. Our contacts ranged from psychiatric hospitals, such as Gaeblers, to recreational/supportive groups like the Big Brother Association. The "lower level" group created a hypothetical child with a case history of emotional disturbance on whose behalf they were seeking help. They posed as the child's aunt/uncle and called a variety of caregivers

who they thought a parent or concerned relative in a similar situation might call. Their phone contacts ranged from hotlines, to clergy, police, hospitals, and little City Halls.

Certain discrepancies did emerge in what a service professed to provide and what it actually did. These differences will be mentioned to parents where relevant. Our handbook takes into account the legal rights of emotionally disturbed children in Massachusetts to treatment, special education and other services. The handbook includes a listing of a wide range of activities and groups in which parents can participate if they are interested in providing direct service for emotionally disturbed children; belonging to a parent group advocating for children's rights; or assuming more of an activist posture in lobbying and negotiating for legislative and political changes.

Once published, we plan on distributing the handbook to places in the hope of reaching those parents who are most lacking this kind of information. Among those places will be emergency rooms in hospitals, doctors' offices, neighborhood health centers, churches, shopping centers and other social agencies. Numerous requests for our handbook were made by many of the individuals we contacted over the course of the summer, since they too felt the lack of coordinated and accurate information regarding services for emotionally disturbed children.

WHAT WE DID

We set out to look at the Mental Health facilities and services available to children in the Allston/Brighton area.

WHAT WE FOUND

We found lots of offices, some bureaucracy, some mental health clinics, some special schools, and some children oriented organizations; but we wondered if parents know that they existed. If you are a parent, where and how do you get help for your child if he or she has an emotional problem? We began to suspect that even though Allston/Brighton does have some mental health facilities and services available, and that there are some children who would benefit from these services, there just isn't very much information available telling parents about these services and telling them how to go about getting help for their children.

AND SO...

The purpose of this booklet is to tell parents what mental health services exist for children in the Allston/Brighton area and how to contact and use these services. The following list of facilities and services is by no means complete. We just began to scratch the surface. Any agencies, either public or private, that are not listed in this booklet, but would like to be included at some future date, please contact the Center for Law and Health Sciences, Boston University School of Law, 765 Commonwealth Avenue, Boston, Massachusetts 02215.

CHILDREN'S PROBLEMS AND PARENTS

Any way you look at it, growing up in the city is difficult. All children have problems. That's a very normal and natural part of growing up. These problems are caused by lots of things -- like school, other children, adults, a changing and often confusing society. Sometimes these problems get too big and too serious for children or parents to handle by themselves. There are places and people in the Allston/Brighton area who can help children learn how to handle and solve their problems. If you think your child would benefit from some outside help, don't hesitate to contact some of the places suggested in this booklet. Trust your own judgement.

BETH ISRAEL HOSPITAL
330 Brookline Avenue
Boston
734-4400 x654

HOURS

8:30 - 5:00 Monday through Friday. Call or go to the emergency room after regular hours.

SERVICES

The Children's Psychiatric Unit at Beth Israel offers primarily out-patient services; although there are a few beds available for adolescents over 15.

1) Thorough evaluation and diagnosis
2) Individual, group and family therapy
3) Volunteers to babysit for other children in the family when mother and child come for an appointment.

NOTE

Phone or walk in. The waiting period is never over a month, and they will always make time for an emergency.

BOSTON CHILDREN'S SERVICE ASSOCIATION
13 Walnut Street
Boston

227-3800

HOURS

Weekdays 9-5, Wednesday evening, 24 hour emergency phone

COST

They use a sliding scale. Their maximum charge is $25 per family per week, regardless of the number of contacts.

SERVICES

They provide foster care in family or group homes, adoption services, services to unwed parents, counseling to adjudicated children, counseling for children and their families.

NOTE

Call them directly for an appointment or contact the Fidelis Way Information Center.

BRIGHTON/ALLSTON MENTAL HEALTH CLINIC
330 Market Street
Brighton (In Ste. Columbkills Convent)

787-1901

HOURS

9 to 5 weekdays. Evening hours can be arranged for working parents.

COST

They use a sliding scale from $0 to $10.

SERVICES

They provide mental health service to the Brighton community. They are limited primarily to outpatient treatment. They are a good source of referral information as well.

NOTE

Call or drop in.

CHILDREN'S HOSPITAL MEDICAL CENTER
300 Longwood Avenue
Boston

734-6000 x2071

HOURS

9-5 Monday through Friday. 24 hours emergency service

COST

$18 for the first medical examination. $25 per visit for treatment. Fees are negotiable however.

SERVICES

Children's Hospital offers inpatient and outpatient services for children under 12 who have both psychological and medical problems. They do not work with purely emotional problems.

1) Evaluation and diagnosis
2) Counseling for parents
3) Psychotherapy for children

NOTE

Call and ask for the intake worker. He or she will discuss the child's problems with you on the phone to see if the child can be treated at the hospital. If not, appropriate referrals will be made. The waiting period is from 4 months to a year.

CHILD AND YOUTH CLINIC
St. ELIZABETH-STORROW HEALTH CLINIC
14 Lothrop Street
Allston AND St. Elizabeth's Hospital
\
254-6046

HOURS

9 to 4 weekdays

COST

Free

SERVICES

They work with those who can function with weekly outpatient counseling without a psychiatrist. They will diagnose and refer more serious or specialized cases.

NOTE

It is necessary to call and make an appointment.

CONCERNED JEWISH CITIZENS (CJC)
Congregation Kademah-Toras Moshe
113 Washington Street
Brighton

254-1333

HOURS

Monday through Thursday 9 to 4

COST

Free

SERVICES

CJC offers limited counseling to Jewish families and people of all ages. Besides counseling and making referrals the Temple runs a Hebrew School and Youth groups which children with mild emotional problems can attend. CJC can help you get in contact with other agencies and can help navigate a child through the system.

NOTE

To contact them simply phone or drop in.

FAMILY COUNSELING AND GUIDANCE CENTERS, INC.
49 Franklin Street
Boston

542-0903

HOURS

Monday through Thursday 9 to 9. Friday 9 to 5

COST

$20 per visit by unit of time

SERVICES

On an outpatient basis, they provide counseling, guidance and psychotherapy.

NOTE

Make an appointment. Beyond a first visit, they won't treat children under 18 without parental consent.

FAMILY DAY CARE PROGRAM
WOMEN'S EDUCATIONAL & INDUSTRIAL UNION
264 Boylston Street
Boston

536-5651

HOURS

Monday through Friday 9 to 5. Day care is provided between 6:30 a.m. and 6:30 p.m.

COST

$42.50 per week though this is negotiable

SERVICES

The Family Day Care Program provides 1) day care for children 0-8 in a home setting 2) a training program for women wishing to start a program in their own homes. At present the day care people are not specifically trained to work with emotionally disturbed children though they do have extensive contact with such children. The union is in the process of re-designing the training program so that the day care program can more adequately serve these children. At this point they probably can provide referral information.

FAMILY SERVICE ASSOCIATION OF GREATER BOSTON
34½ Beacon Street
Boston

523-6400

HOURS

Monday through Friday 9 to 5. Wednesday evening until 8:00.

COST

Sliding scale $1 to $25 per interview based on income.

SERVICES

Non-sectarian, non-profit family counseling agency which provides service to those who need and want help with their personal or family problems. They counsel parents and children.

NOTE

It is recommended that people call in and make an appointment except in the case of an emergency.

FIDELIS WAY INFORMATION AND REFERRAL CENTER
34 Fidelis Way (basement)
Brighton

783-0430

HOURS

Monday through Friday 9 to 5

COST

Free

SERVICES

They provide some outpatient counseling and guidance. They are an excellent source of information. When they don't provide direct service they are a good referral source.

NOTE

Phone for an appointment or drop in.

GAEBLER'S CHILDREN'S UNIT,
METROPOLITAN STATE HOSPITAL
475 Trapelo Road
Waltham

894-4300

SERVICES

The Children's Unit is a state hospital for children up to the age of 16 who have severe emotional problems. Both residential treatment and day treatment are provided.

1) Individual and group psychotherapy

2) Occupational therapy

3) Day school and vocational school

COST

Residential treatment is $15.35 per day although this is negotiable. Many local mental health centers assume much of the cost for children from their area. The day school program is paid for by the state.

NOTE

To get in, take the child to a local mental health center or to a near-by hospital with a psychiatric clinic. If the child's problem is severe enough he will be referred to Gaebler's. There is no waiting list.

JEWISH FAMILY AND CHILDREN'S SERVICE
31 New Chardon St.
Boston
227-6641

233 Harvard Street
Brookline
566-5716

HOURS

Weekdays 9 to 5. Emergency service at 227-4641

COST

$0 to $20 sliding scale depending on income.

SERVICES

They provide counseling and therapy, foster and adoptive care to members of the Boston Jewish community; however the agency has no religious limitations.

NOTE

Phone their intake worker and make an appointment

JUDGE BAKER GUIDANCE CENTER
295 Longwood Avenue
Boston

232-8390

HOURS

Monday through Friday 9 to 5. Some evening appointments

COST

Sliding scale with a maximum fee of $25 per visit.

SERVICES

This center is a clinic for the treatment of emotionally disturbed children. Outpatient services are available for both boys and girls. The Manville School for boys which is located at the Center is a special education school for both day students and residential students. The center provide facilities for diagnosis and evaluation; individual, group, and family therapy; counseling for parents; and some adolescent boys groups and parent groups.

NOTE

Contact the intake worker for the Allston Brighton area. The waiting period can range from a few days to 6 months.

KENNEDY MEMORIAL HOSPITAL FOR CHILDREN
50 Warren Street
Brighton

254-3800

HOURS

8:30 to 5:00

COST

Negotiable

SERVICES

They work with multi-problem children with physical as well as emotional problems; suspected retarded, learning disabilities, neurological dysfunction. They will refer children with primary emotional problems elsewhere.

NOTE

Phone for an appointment.

LEDGEWOOD HOME FOR JEWISH CHILDREN
1000 Harvard Street
Mattapan, Massachusetts

296-6800

HOURS

Contact them weekdays 9 to 5.

COST

Sliding scale depending on income.

SERVICES

They provide a residential treatment facility for emotionally disturbed adolescent boys. They provide counseling and guidance as well as psychotherapy. They deal only with moderately disturbed children, usually borderline chronically depressed and deprived.

NOTE

An appointment is necessary and must be made by a state or a private agency.

MASSACHUSETTS GENERAL HOSPITAL
32 Fruit Street
Boston

General hospital 726-2000
Psychiatric Unit 726-2724

HOURS

Monday through Friday 9 to 5. Other times go to Acute Psychiatric Services

COST

$22 per visit though this is negotiable.

SERVICES

MGH provides outpatient services for children with a medical record or who have been referred by an MGH physician. They offer diagnosis and evaluation, individual and group psychotherapy, some family therapy, and counseling for parents.

NOTE

Call the intake worker for the initial visit. After the first visit there may be a two to six month waiting period.

MASSACHUSETTS MENTAL HEALTH CENTER
74 Fenwood Road
Boston

734-1300

HOURS

Weekdays 9 to 5.

COST

$5 for initial visit and outpatient consultation. Sliding scale for regular visits from 50 cents to $10.

SERVICES

They provide diagnosis and treatment for children up to the age of 17½ who are presenting some behavioral characteristics which are causing them to get into trouble at home, at school, or in the community. They provide counseling and guidance as well as psychotherapy.

NOTE

Be sure to make an appointment. In an emergency just drop in.

THE NEW ENGLAND HOME FOR LITTLE WANDERERS
161 S. Huntington Avenue
Boston

232-8600

HOURS

They may be contacted 9 to 5 daily.

COST

$6,000.00 per year

SERVICES

They provide a variety of placement services for emotionally disturbed children including group homes, specialized foster homes, adoption services to provide counseling to unwed mothers and to recruit additional foster and adoptive homes.

NOTE

Be sure to call for an appointment.

NEW ENGLAND MEDICAL CENTER
260 Tremont Street
Boston

426-0269

HOURS

Weekdays 9 to 5. Wednesday evenings can be arranged.

COST

Sliding scale from $1 to $26 depending on income and number of family.

SERVICES

They provide comprehensive mental health services, specifically counseling and guidance on an outpatient basis. Psychotherapy is also available.

NOTE

Be sure to make an appointment.

PROJECT PLACE
32 Rutland Street
Boston

267-9150

HOURS

Daily 9 to 5. 24 hour telephone counseling and referral.

COST

Free

SERVICES

They provide guidance and counseling on a short term basis. They are a good source of information. If they can't offer direct service they will refer you to someone who can.

NOTE

It's easier to make an appointment but feel free to drop in any time.

TASK FORCE ON CHILDREN OUT OF SCHOOL
889 Harrison Avenue
Boston

445-6129

HOURS

Weekdays 9 to 5.

COST

Free

SERVICES

The Task Force has an information and referral service to aid the parents of any child out of school in Boston. The children served include the physically and emotionally handicapped, retarded, the disruptive child and children seeking a transfer. Task Force workers will deal directly with the schools. Under Massachusetts law, every child has a right to be in school. The law allows for payment of the costs of private schools within or without the Commonwealth whenever there is no suitable public school available to a child. The Task Force's goal is to see that no child is denied his right to an education.

NOTE

Call them directly to discuss any problem concerning a child out of school.

WHAT ELSE CAN BE DONE

If you are the parent of a child with an emotional problem or just a citizen concerned about such children, there are things you can do to help. Parent and community groups work to change the laws and to oversee the facilities that are providing care. Many agencies actively desire the advice of concerned citizens so that they may make their services more responsive to individual and community needs. Here are some of the organizations you might wish to contact if you want to get involved.

ASSOCIATION FOR MENTALLY ILL CHILDREN
755 Boylston Street
Boston, Massachusetts

261-2639

This is a parents' group which actively works to change laws, seek placements for children, and to see to it that needed new services are provided. They have even brought a suit against the state for failure to provide suitable placements for some children.

THE COALITION FOR CHILDREN
c/o Dr. Ronald P. Dutton
125 Lowell Avenue
Newton, Massachusetts

969-3444

The Coalition is composed of representatives from a number of child concerned groups, professional people, concerned citizens and even some children. For an individual to join they must be willing to work on one of the Coalition's Task Force committees which in the past have worked in the areas of ingested poisons, child abuse and special education. The Coalition also actively lobbies for needed legislation.

THE MASSACHUSETTS CHILDREN'S LOBBY
145 Pickney Street
Boston, Massachusetts

This is a group of concerned citizens who try to work together to exercise political muscle to have elected officials consider legislation for children.

Beyond this each parent or citizen may contact his or her local representatives to let them know that you are concerned about the needs of children with special problems and to ask that your representative give some attention to the needs of these children.

The mental health professions have not always recognized that children, like adults, may become emotionally disturbed. As a result, there hasn't been a great deal of money or energy channeled into children's mental health care. That's beginning to change. There is an increasing awareness of the need to provide facilities and services for children with emotional problems. But we've got a long way to go. However, there are some people who are concerned and are willing to offer assistance to children who need it. If you feel that your child needs help, take advantage of the resources that are available. Don't wait for a problem to become serious. If you do, then the odds that treatment will be successful are considerably reduced. There are simply fewer facilities available to treat severely disturbed children.

It is an unfortunate fact that many people are frightened or ashamed of mental illness in their family. We won't tell you otherwise. But we will say that feeling that way is a mistake. If you avoid a problem it will probably get worse. If you don't seek help for someone who needs it; if you don't pressure the government and the mental health professions to pro-

vide services that people need, then nothing will change. So, for the sake of your child, for your own benefit, and the benefit of your community, please seek help for your child if he or she needs it. Good mental health care is partly your responsibility.

Grant Number: OCD-CB-431

Title of Project: Student Surveys of Policy Issues Related to Children

Principal Investigator: Freda Rebelsky

LEGAL PROBLEMS OF PROVIDING MEDICAL CARE TO MINORS

Center for Law and Health Sciences
Boston University School of Law
Summer, 1972

In Massachusetts the laws concerning a minor's ability to receive medical care without parental consent are vague, if not nonexistent. There are three statutes that attempt to clarify and broaden the law in certain specific situations, but these are quite limited in purpose and at times confusing. Therefore, one must resort to the common law in order to discuss the legal problems a minor might encounter upon seeking medical care on his own. It might be more accurate, as a matter of fact, to point out that the law does not prohibit a minor from seeking medical care but threatens the minor's doctor with potential liability, thereby causing the doctor to avoid treatment.

The basic problem the doctor potentially faces when he treats a minor without parental consent is a suit for assault and battery. Technically a battery is any contact with a person to which that person has not consented. "The gist of the action for battery is not the hostile intent of the defendant, but rather the absence of consent to the contact on the part of the plaintiff."[1]

The purpose of the action is to protect the integrity of the plaintiff's person. For this reason a perfectly harmless, but offensive, touching entitles one to recover at least nominal damages and possibly damages for the mental disturbance inflicted upon him such as fright or humiliation.[2]

A defendant may be liable even where he intended only a joke, or perhaps a compliment such as a kiss or a misguided effort to

render assistance.[3] For example, Prosser cites the case of Ragsdale v. Ezell[4] in which the defendant was found to have forcibly hugged and kissed a married woman. This unceremonious conduct cost him $700.

As explained above, a battery is an unconsented to touching. Therefore, if one consents to be touched, there is no battery. The reason battery is a special problem when medical treatment involves minors is that minors are legally incapable of giving consent.[5]

The justification most often given to this rule is that minors are too immature to have sound judgment and therefore must be protected from their elders, who might take advantage of them.[6] This attitude is exemplified in the case of Bonner v. Moran,[7] in which a fifteen-year-old boy consented to be the donor in a skin transplant which his cousin required. The plaintiff brought an action for assault and battery. The trial court found for the defendant, adopting the attitude of §59 of the Restatement of the Law of Torts, which states that if the child is capable of appreciating the nature, extent and consequences of the invasion and gives his consent, there is no battery. In reversing the trial court, the appellate court notes

> In deference to common experience, there is a general recognition of the fact that many persons by reason of their youth are incapable of intelligent decisions, as a result of which public policy demands legal protection of their personal as

> well as their property rights. The universal law, therefore, is that a minor cannot be held liable on his personal contracts or contracts for the disposition of his property.... Hence it is not at all surprising that, generally speaking, the rule has been considered to be that a surgeon has no legal right to operate upon a child without the consent of his parents or guardian.[8]

Thus, the court in Bonner gives the justification for the common law rule concerning the minor's incapacity to contract and then applies it by analogy to a case in which the issue concerns the minor's ability to consent to medical procedures. In doing this, the court is trying to extend the law's protection of minors from one field to another, for the infant's incapacity to enter into a binding contract is said to be for his own protection. This attitude was expressed by Blackstone when he stated,

> Infants have various privileges, and various disabilities; but their very disabilities are privileges; in order to secure them from hurting themselves by their own improvident acts.[9]

Infancy, in common law generally and in Massachusetts, terminates when an individual attains the age of twenty-one.[10] In recent years the arbitrary nature of the age of majority has come under increasing attack,[11] and it would therefore be of interest to see how the age of twenty-one was selected as the age of majority, and whether it still makes sense in 1972.

In Gaius' work concerning Roman Law he pointed out that, "...It is the dictates of natural reason that persons of immature years should be under foreign guidance and control."[12] For males

the attainment of puberty brought about their release from wardship. In early Rome there were two schools of thought concerning the onset of puberty. One school believed that puberty depended on one's capacity of generation; in the case of impotence one was released from wardship at the age of eighteen, which was presumed to be the age when even the latest "bloomer" would be able to reproduce. The other school held that puberty should be exclusively measured by age, which they determined was fourteen. The theory of the second was eventually adopted, and in later Roman law wardship ceased at fourteen years for males and twelve years for females.[13] However, one wonders how much the purpose of the law was for the protection of the infant, as the father had total control over the child and could sell the child into slavery or even kill the child if the father so desired.[14]

In England the capacity to perform certain tasks was a test utilized to determine when one attained one's majority. The borough court which had the wardship of orphans would determine the majority of its wards by examining them to see whether they could count and measure and whether or not they knew a good penny from a bad one.[15]

In ninth and tenth century England, the age of majority was set at fifteen years. But in the eleventh and twelfth centuries, with the advent of combat on horseback which required additional

training and the use of heavy armor and weapons, the age was raised to twenty-one years in order to allow for development of greater physical strength and longer training.[16]

Even in Rome the age of fourteen was chosen for a logical reason. It was at that age when it was assumed that the "pupil" had knowledge and understanding of the law, particularly the laws that related to property rights.[17]

In France the age of consent was seventeen until the tenth and eleventh centuries, when nobles took up training in arms which required strength which one did not acquire until he reached twenty-one.[18]

Among the barbarian tribes infancy could be terminated at fifteen years, which was also the vital age for combat.[19] This is not unlike the argument of those who advocate the eighteen-year-old vote, which states, "One who is old enough to fight is old enough to vote."

One writer on the subject states that no one age for the termination of infancy is entirely equitable because different children mature at different ages, but he goes on to say that the choice of the age of twenty-one is as good as any other. He also points out that human life is divided into four periods, each of which is a multiple of seven.

> Natural infancy ends at seven years, puberty begins at fourteen, legal infancy ends at twenty-one years, and the natural life of man is three-score years and ten.[20]

This is an interesting point, but one would hope modern legislatures would rely on something other than numerology to set an age of majority.

One must note, to a certain degree, that the age of majority was originally based somewhat on logic, on the minor's ability to perform certain acts, on his reaching of puberty, and on his ability to perform military tasks. However, one must ask whether the age of majority really had anything to do with protecting the minor, or to put it another way, were his disabilities really privileges? In Roman law, as already noted, a father could kill his minor child or sell him into bondage. In feudal law if a tenant died leaving a minor heir, the lord was allowed the profitable rights of wardship and marriage. The lord had full use of his ward's land and had no obligation to render an account to the minor. Upon attaining majority, the ward had to sue for possession and pay a half year's profit to the lord to receive his own land. Although this system prevents a minor from squandering his inheritance, it is a rather expensive means of protection.[21]

Under common law a father is entitled to all of his child's earnings. One way of insuring the father's receipt of these earnings was to prevent the minor from spending them and this was accomplished by rendering the minor incapable of entering into a binding contract. It also protects the father's goods in that a

minor could not sell any of his father's property and convert the proceeds to his own use.[22]

So it appears that the age of majority is based on the customs of a medieval society, involving knighthood and nobles, and property rights, and having very little, if anything, to do with the protection of minors. It would seem that to use this as a basis for setting the age when a minor can consent to twentieth century medical procedures is illogical and fanciful.

Another indication that the age of majority had little to do with the protection of minors is based on the fact that common law permitted the minor to enter into several endeavors of a serious and permanent nature. According to Blackstone,[23] a male at the age of twelve may take the oath of allegiance; at fourteen, he is at the age of discretion and may consent to or disagree to manage, may choose his guardian, and if his discretion is actually proved, may make a testament of his personal estate; and at seventeen, he may be an executor. A female may be given in marriage or betrothed at seven; at nine she is entitled to dower; at twelve she may consent to or disagree to marriage, and if found to have sufficient discretion, may bequeath her personal estate; and at seventeen she may be an executrix.

Massachusetts statutes have likewise carved out areas in the law that give minors certain rights. For example, in Massachusetts

a fifteen-year-old is deemed competent to contract for life insurance,[24] may be licenced to drive a car at seventeen with his parents' permission, and at eighteen without his parents' permission,[25] may get married without parental consent at eighteen,[26] and may commit himself to a mental hospital at the age of sixteen.[27]

With the exception of M.G.L.A. c. 123 §32, which states that the parents of a minor may be liable for expenses incurred by a minor who is committed to a mental hospital, it is notable that the exceptions listed above do not cost the parents of the minor anything. And this may indicate the real reason a minor cannot consent to medical treatment. Justice Hart states in his concurring opinion in Lacey v. Laird,[28] that,

> This rule [that a minor cannot consent to medical treatment] is not based upon the capacity of the minor to consent, so far as he is personally concerned, within the field of the law of torts or the law of crimes, but is based upon the right of the parents whose liability for support and maintenance of their child may be greatly increased by an unfavorable result of the operational processes upon the part of the surgeon.

Justice Hart seems to be saying that since a parent is responsible for the care and maintenance of a minor child, the parent should have control over any activity that would increase the cost of such care. This is similar to the theory that one sees repeatedly, that a parent has a right to tell his child where he will live, what he will eat, how he will dress, and to command obedience because the parent has the duty to support the child.[29] This is also a reflection of the child as property theory, something the

parents must pay for and therefore have the right to control. As was stated in Bakker v. Welsh,[30] the general rule is the father is the natural guardian of the child and is therefore entitled to his custody and services and cannot be deprived of either without his consent.

The above rule, that a minor cannot consent to be treated medically, has been attenuated in certain jurisdictions by court decision. There is the "mature minor rule" which states that if a minor understands the nature and consequences of treatment, he may consent to such treatment.[31] The cases most frequently cited to support this rule are Lacey v. Laird[32] and Bakker v. Welsh.[33]

In Lacey, an eighteen-year-old girl had plastic surgery performed on her nose and then sued her doctor for assault and battery. The trial court charged, among other things, that a minor who is eighteen years of age cannot consent to a simple operation. The court of appeals reversed, and the Supreme Court of Ohio affirmed the appeals court in a per curiam decision. Justice Hart, in his concurring opinion, comes to the conclusion that a minor may never consent and that therefore any procedure performed on a minor is an assault and battery if parental consent was not acquired. However, he goes on to say that such an assault and battery is merely a technical one and therefore the plaintiff can recover only nominal damages, which is very often one dollar. As

the trial court charged that damages could range up to $25,000, Justice Hart voted to affirm its reversal.

Justice Taft, on the other hand, writes that a minor of eighteen may consent to a simple operation and therefore there is no assault and battery at all.

Whether or not there actually is an assault is more than a fine point of legal philosophizing. Since the parents of a minor are entitled to his services and earnings, if a doctor performs a medical procedure which wrongfully deprives them of their child's earnings and services, then the parents should have a cause of action against the doctor. Due to the conflict in the Taft and Hart opinions, a doctor who operates on a "mature minor" has no way of knowing whether he may be liable to a minor's parents as a tortfeasor.

In the Bakker case, Stephen Bakker was seventeen years old when he was accompanied to the defendant doctor's office by his two adult sisters and a sixty-year-old aunt. Dr. Welsh examined Bakker's ear and then instructed him that he wanted him to consult a specialist. After seeing the specialist, Bakker returned to Dr. Welsh with one of his adult sisters, at which time Dr. Welsh told Bakker he had a tumor in his ear and that a surgical procedure was required. Bakker was later accompanied to the hospital by his aunt and one sister, both of whom were aware of the fact that surgery was to be performed. Bakker's father never consented to

the operation, and the boy died on the operating table. The court, in holding that the doctor was not liable for assault and battery, pointed to two facts: 1) The "young fellow" was almost grown into manhood; and 2) he was accompanied by some adult relative at all times. Which of these two facts the court found more important is difficult to say, but it does rely on both and not just the maturity of the minor.

There is at least one case, however, where the fact that medical treatment given to a minor was consented to by an adult relative did not save the doctor from liability. In Moss v. Rishworth[34] an eleven-year-old child died after an operation to remove her tonsils and adenoids. There was no parental consent; however, the operation was consented to by the adult sister of the minor child. The court held that only the parent could make the decision concerning the welfare of the child and therefore the doctor committed an assault and battery. What is especially interesting in this case is that the adult sister who gave her consent had three years of experience in training to become a graduate nurse. For this reason it is most probable that the sister could better understand the necessity for and risks inherent in the operation and could therefore protect the child's interest better than the parent. It therefore seems the court was not really interested in the protection of the child but only with the right of the parent to control the child's affairs.

One interesting point that the mature minor rule indirectly makes is that one's capacity to consent has nothing to do with one's capacity to contract. In the field of contracts there is no mature minor rule. According to Williston,

> No distinction generally has been drawn so far as concerns contractual capacity between a minor of tender years and one who, having nearly attained his majority, has ample intelligence in fact.[35]

There are many cases which bear out this statement. In Babtkus v. Jutras[36] the plaintiff attempted to recover the balance of $800 due on a promissory note of $2,000 which the defendant had disaffirmed upon reaching her majority. The note was made when the defendant was twenty years old. The court found for the defendant, restating the policy of the Commonweath, which is to protect minors from their lack of sound, mature and competent business judgment. Even in the case of a twenty-year-old who bought a truck for his and his partner's use in their gravel hauling business, the court allowed the minor to escape his contract.[37] As one writer has commented, "There is an incredible judicial tenacity to the infancy doctrine." It is "one of the most cherished and protected policies of our whole body of laws."[38] As it is still the almost universal policy of the courts to allow a minor of any age to disaffirm his contracts, it would be most improbable for the courts to create the mature minor rule if the incapacity of a minor to consent to medical care was based on the law of contracts.

As Taft's concurring opinion in the Lacey case demonstrates, minors are allowed to consent to certain contacts which would be batteries if there were no consent. He asks rhetorically,

> ...Does any boy who kisses a girl under twenty-one with her consent but without the consent of her parents thereby expose himself to an action for assault and battery; and does every high school football player run the risk of assault and battery actions by boys under twenty-one with or against whom he plays?[39]

Common sense as well as case law indicate that the answer is no. For example, in Vendrell v. School District No. 26c,[40] a fifteen-year-old high school freshman had his neck broken in a football game. He brought a negligence action against the school system, which entered a defense based, among other things, on the assumption of risk of the plaintiff. The court held,

> One who enters into a sport, game or contest may be taken to consent to physical contact consistent with the understood rules of the game.

The assumption of risk defense has been used elsewhere against minors. In Porter v. Toledo Terminal R. Co.,[41] a thirteen-year-old boy was injured when he rode his bicycle over rotten railroad tracks, and in Centrello v. Basky,[42] a ten-year-old boy fell and caught his hand in a cement mixer while playing near a construction site. In both of these cases the defendants were allowed to utilize the assumption of risk defense.

In Massachusetts there is the case of Pouliot v. Black,[43] in which a ten-year-old boy was struck in the head with a golf ball

while he was in the process of collecting golf balls that had been hit from practice tees. The defendant pleaded contributory negligence and assumption of risk, and the verdict was directed for the defendant. The court found that the boy had caddied six or eight times before and had collected balls for about half an hour before being struck. With the knowledge derived from this experience, the court found that the plaintiff voluntarily exposed himself to a known and appreciated risk.

The theory of assumption of risk is expressed in the maxim, Volenti non fit injuria, which means, "He who consents cannot receive any injury."[44] It is based on the knowledge and appreciation of the risk and the voluntary encountering of the risk.

The court in Pouliot had to find that the ten-year-old plaintiff was capable of understanding the risk involved in collecting golf balls and was able to understand the amount of damage that would occur if he was struck by the ball. This ability to comprehend risks is exactly the reasoning courts have utilized in promulgating the mature minor rule. That is to say that they have determined that a certain plaintiff is capable of understanding the risks and consequences of a certain medical procedure and may therefore consent to it. But if a boy of ten is capable of consenting to being hit on the head with a golf ball, which does him harm, why is he incapable of consenting to medical care, which does him good. Therefore, as a matter of logic the mature minor rule

should be transformed into the intelligent minor rule so that anyone, regardless of age, who can understand the risks involved in a medical procedure could consent to it. In fact, such a rule has been written into the statutes of Mississippi. As of 1966,

> Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical procedures [may consent to such procedures].[45]

A second exception to the general rule of consent is that an emancipated minor may consent to medical treatment in certain jurisdictions.[46] In Massachusetts there is no decision that supports this doctrine. Emancipation is defined as the freeing of a child from the care, custody, control and service of its parents. Emancipation may be expressed or implied.

In order to determine how the Massachusetts courts might determine who is an emancipated minor and the rights of such minors, one must go to cases written in antiquity. The clearest statement of emancipation is found in the 1818 case of Nightingale v. Withington.[47] The court stated that the right of the father to the earnings of his child is based on his duty to nurture and support the child. But where the father no longer supports the child, or where he forces the child to support himself, the father has no right to his earnings. The court continues,

> Thus, if the father should refuse to support a son, should deny him a home, and force him to labor abroad for his own living...the law will imply an emancipation of the son.[48]

The rights that accrue to an emancipated minor were discussed in another case decided in the same year as Nightingale. In The Inhabitants of Taunton v. The Inhabitants of Plymouth,[49] the issue was whether or not a minor who was married with his father's consent could acquire a settlement,[50] although settlements could be acquired exclusively by adults. The plaintiff contended that although he was a minor, he was emancipated by his marriage and was therefore capable of gaining a settlement. The court disagreed, "Our courts, however, know of no such emancipation; or, at least, do not recognize such consequences of it." The marriage may have removed the minor from the control of his father and may have given him the right to use his earnings to support his family. "But it did not give him a capacity to make binding contracts, beyond other infants; or any political or municipal rights, which do not belong by law to minors." Needless to say, the court held that a minor could not gain a settlement.

Commonwealth v. Grahm[51] is a case concerned with non-support. The husband involved married at the age of nineteen, and the action was commenced when he was twenty. He argued that, since a minor is obligated to give all his earnings to his father, he could not be forced to support his wife. The court quoted a Vermont case[52] which stated,

> The husband becomes the head of a new family. His new relations to his wife and children create obligations and duties which require him to be the master of himself, his time, his labor, his earnings and conduct.

The court found that an infant husband must support his wife and he is therefore entitled to his own wages "so far as they are necessary" to support himself and his family. This seems to be a type of partial emancipation because the court implies that any wages not necessary for the support of his household may be taken by his father. The decision also affirms the point that emancipation does not mean all the disabilities of infancy have been removed, but only that the infant is freed from parental control and has a right to his earnings.

The court noted that a female definitely becomes emancipated when she marries. This is unquestionably true at common law, where a wife was under the total control of her husband. She could not be under the control of her father and her husband simultaneously; therefore, control over her passed from one to the other at the time of marriage.

Likewise, a minor who enters the military is undoubtedly emancipated.[53] Such a minor is no longer supported by his father, and is under the control of and owes his first obedience to the military.

A case that excellently demonstrates the emancipated minor rule is Smith v. Seibly.[54] In this case an eighteen-year-old minor who was married, employed, self-supporting and a father decided to have a vasectomy performed because he was suffering from an incurable disease and wanted to limit the size of his family.

He and his wife visited a doctor who explained the procedure to them. They decided to consider the procedure for a while longer and left the office with a consent form which they could study. Twelve days later Smith returned to Dr. Seibly's office with the consent form signed by himself and his wife. The operation was performed successfully. After attaining his majority, Smith brought an action alleging that the doctor was negligent in performing the vasectomy upon an infant of eighteen years, was negligent in failing to explain the permanent consequences of the surgery and that the surgery was performed without valid permission. Although negligence language was employed, all parties agreed that the trial court correctly submitted the case to the jury on an assault theory. The court found for Dr. Seibly. It said that a married minor, eighteen years of age, who has successfully completed high school, and is head of his own family, who earns his own living and maintains his own home is emancipated for the purpose of giving a valid consent to surgery. The court listed the following factors to be considered when determining whether a minor is emancipated for the purpose of giving consent - age, intelligence, maturity, training, experience, economic independence or lack thereof, general conduct as an adult and freedom from the control of parents.

Why is it that a court should allow an emancipated minor to consent to medical treatment? It obviously has nothing to do with

a minor's right to contract because, as shown above, emancipation does not give a minor the capacity to contract. The criteria of age, intelligence, maturity, training, experience, and general conduct as an adult have nothing to do with emancipation because all of these factors can be present in a minor who is still under the strict control of his parents. These attributes really apply more to the mature minor rule in which it was stated that a minor who can understand the consequences and implications of a medical procedure may consent to that procedure. The emancipation rule is really the mature minor rule with the added requirements of freedom from parental control and economic independence. The emancipation doctrine makes perfect sense if one realizes that the incapacity of a minor to consent has nothing to do with his right to contract but instead is involved with the fact that a parent has a right to complete control over his child's actions and has a right to the services and earnings of his child and therefore must consent to any occurrence that will deprive him of these rights. By definition a parent has no right to control an emancipated minor, and has no right to his earnings and services and has no duty to support the minor. For this reason the courts need not protect the parent when an emancipated minor wishes to undergo some medical procedure.

California has enacted the emancipated minor rule into law. Section 34.6 of the California Civil Code states that a minor who

is fifteen years old or older, and who with or without their consent is living apart from his parents regardless of the duration, and who is managing his own financial affairs, regardless of the source of his income, may consent to medical and surgical treatment.

The application of this statute, as with the application of the emancipated minor rule, could prove to be quite a problem because emancipation is a question of fact, and applying the law to a specific situation is difficult. For instance, what does "living separate and apart regardless of the duration" mean? What about a minor who lives in a college dormitory, or one who is visiting a friend for the weekend? What does it mean to "manage" one's own financial affairs? What if a college student's parents paid for his room and board by sending a check directly to the college? Would it make any difference if his parents sent the student the money and then the student wrote the check? All in all, the statute, like the emancipation doctrine, is rather foggy and difficult to employ.[55]

The final exception to the rule that minors may not consent to medical treatment is the emergency rule. The emergency rule states that if a minor is in danger of losing his life or limb if treatment were not immediately forthcoming, then a physician need not wait to receive parental consent before giving treatment. This

rule as it applies to minors is merely an extension of the rule as it applies to adults. If an adult is brought into an emergency room unconscious and in critical condition, his consent to a medical procedure that will save his life or limb is implied. This same reasoning applies to a seriously ill or injured child who is brought to a hospital or doctor's office - that is, it is presumed that if a parent were present he would consent to the treatment of the child.[56]

Massachusetts, as well as several other states, has codified the emergency rule. In Massachusetts a physician will not be held liable for damages for failure to obtain parental consent in order to conduct an emergency examination and treatment of a minor child "when delay in the treatment will endanger the life, limb, or mental well being of the patient...."[57] Under this statute, as well as under the common law emergency doctrine, the doctor must make the decision as to whether or not a "delay" in treatment will endanger the life, limb or mental well being of his patient. In Rogers v. Sells,[58] the defendant doctor amputated a foot of a fourteen-year-old boy who was involved in an automobile accident. The doctor was sued on the ground that there was no consent and the doctor defended by contending that the situation was an emergency. The jury was presented with conflicting evidence, decided there was no emergency, and set the damages at $8,000. Thus, as this case

suggests, there are situations in which a doctor will have to make hard decisions as to whether he is really faced with an emergency, and he may find that a wrong conclusion could be quite costly.

Another problem a minor might encounter when he contacts a physician concerns "informed consent." Under this doctrine courts have ruled that a patient cannot consent to a particular procedure unless he has been warned of the risks and hazards that accompany it.[59] In the past ten years, twenty-two jurisdictions, Massachusetts among them, have evolved standards concerning a course of action based on lack of informed consent.[60] Valid consent as used in the law of battery implies voluntarily accepted medical treatment after a reasonable disclosure of its essential nature.[61] So the doctor has a duty to disclose material risks, but is also under a duty not to unduly alarm the patient.[62] It might be felt that due to the minor's youth he is not able to understand the risks and hazards that accompany a certain procedure and cannot therefore give informed consent. However, it must be pointed out that, for the most part, doctors feel that modern medical procedures are so scientifically complex, and many of the risks are so subtle, that it is impossible for any patient to understand what is really about to happen to him and to really understand possible alternatives to the procedure.[63]

Since adults cannot actually understand an accurate description of a proposed medical procedure but are still allowed to consent if

they vaguely understand what is about to happen, there is no reason to discriminate against adolescents and not allow them to consent, because they are in the same position as adults. It is also absurd to claim that one's ability to comprehend a doctor's description of a certain procedure is based on age; it is obviously based on intelligence.

What it boils down to is that under the doctrine of informed consent a doctor must believe that his patient, adult or minor, understands what is being explained, and if he does not, the doctor is opening himself up to a battery action. Under the mature minor rule and the emancipated minor rule, courts insist that the minor be intelligent enough to understand the procedure he consented to. What is being measured there is the minor's ability to give informed consent, so it has already been determined that there are minors who can give informed consent.[64]

As stated earlier, the law concerning medical care to minors in Massachusetts is almost impossible to determine, as there is virtually no case law, and the few statutes concerned with this subject are vague and open to wide interpretation which makes them almost impossible to rely on. The fear invoked by this uncertainty can be seen in three unreported equity cases[65] concerned with the admittedly unusual field of organ transplants. All three cases dealt with adolescent twins, one of whom needed a kidney transplant from the other. The nature of the operation was explained to and

understood by all the children and parents. All concerned consented to the operation, but the doctors still would not perform the procedure because they felt that since the operation was not for the benefit of the donor, neither the parents nor the donor could consent to such a procedure. All the parties went to the Supreme Judicial Court to seek a declaratory judgment. In all three cases the court allowed the procedure but not until it pointed out that the donor would benefit from the surgery because psychiatrists testified that if the surgery were not allowed and the twin requiring the kidney died, the surviving twin would suffer grave psychological consequences. The point to be made is that when the law is unknown and impossible to ascertain, doctors will not treat at their own risk.

The state legislature is apparently somewhat cognizant of the problem, as it has enacted a few statutes that attempt to deal with it. M.G.L.A. c. 111 §117, which attempts to deal with the problem of venereal disease, reads as follows:

> For the purpose of providing treatment for persons suffering from venereal diseases, as defined under section six, and who are unable to pay for private medical care, the department shall, or with the co-operation of local boards of health, hospitals, dispensaries or other agencies may, establish and maintain clinics in such parts of the commonwealth as it may deem most advantageous to the public health, and may otherwise provide treatment for such diseases subject to such rules and regulations as the department may from time to time establish. Cities and towns, separately or jointly, through their boards of health or municipal hospitals, may establish and maintain such clinics. For the purposes of this section,

> providing treatment shall include providing transportation or the reasonable cost of such transportation to and from the place where treatment is given whenever the patient is not able to pay for such transportation.
>
> For the purposes of this section, physical examination and treatment by a registered physician or surgeon acting under the authority of the department of public health upon the person of a minor who voluntarily appears therefor, shall not constitute an assault or an assault and battery upon said person.

The question which arises under this section is whether a private physician who treats a minor suffering from a venereal disease can do so without fear of an action for assault and battery. It seems clear to the writer that this section does not apply to private practitioners. It is "for the purpose of providing treatment for persons suffering from venereal disease...and who are unable to pay for private medical care...." Thus, at the very outset, the statute appears to exclude private medical care. It goes on to say that clinics may be established by boards of health, hospitals, dispensaries and other agencies.

The second paragraph and the first paragraph were written at different times, the second amending the first. The opening phrase of the second paragraph, "For the purposes of this section...," applies to the first paragraph which is involved with people who cannot afford private medical care. It then goes on to discuss the freedom from liability of "registered" physicians and surgeons "acting under the authority of the department of Public Health." A

registered physician is one who is licensed by the Board of Resigtration in Medicine.[66] Every physician in the Commonwealth must be registered to practice. But to be free from liability, a physician must also act under the authority of the Department of Public Health. Private physicians and surgeons are not registered by the Department of Public Health and therefore do not work under its authority, but doctors working in clinics licensed by the Department probably do work under its authority. For this reason, if the statute is interpreted as written, it probably does not encompass physicians in private practice. However, the Department of Public Health apparently interprets the statute differently. They have a one-page letter which recites only the second paragraph of the section, and at the bottom of the page it states, "This act enables physicians to examine and treat minors for venereal diseases without parental knowledge or consent." (Emphasis in original). The issue is not whose interpretation is correct but what will doctors do in light of such possible contradictory interpr tations. It is highly unlikely that any doctor wishes to be a test case and will therefore shy away from treating minors.

Another statutory exception to the rule that a minor cannot consent to his own medical treatment is in the field of drug abuse. M.G.L.A. c. 112 §12E states:

> A minor twelve years of age or older who is found to be drug dependent by two or more physicians may give his consent to the furnishing of hospital and medical care related to the diagnosis or treatment of such drug dependency. Such consent shall not be subject to disaffirmance because of minority. The consent of the parent or legal guardian of such minor shall not be necessary to authorize hospital and medical care related to such drug dependency and, notwithstanding any provision of section one hundred and forty-one to the contrary, such parent or legal guardian shall not be liable for the payment of any care rendered pursuant to this section. Records shall be kept of such care. The provisions of this section shall not apply to methadone maintenance therapy.

The initial problem one finds in examining this section is that in the first sentence a minor twelve years of age or older may consent to the diagnosis and treatment of drug dependency after two or more physicians find him to be drug dependent. The problem is how can the initial two physicians determine drug dependency if the minor cannot consent to diagnosis until after he is diagnosed as drug dependent.

The next sentence, "Such consent shall not be subject to disaffirmance because of minority," is also problematic. The use of the word "disaffirmance" is found most often in the field of contracts. If one finds that the capacity to consent is based in contract, a theory refuted earlier, then this merely means what it says. The other theory is that this sentence applies to the minor's liability for services provided him. In other words, a minor, as well as an adult, enters into two legal relationships with the doctor. One is involved with the field of torts in which the patient

consents to the doctor's treatment and frees him from liability for assault and battery. The other relationship is contractual, in which the doctor agrees to treat the patient and the patient agrees to pay for the treatment. The question is, to which of these relationships does the disaffirmance language apply? Interestingly enough, the language of this section is virtually identical to the language of California's emancipated minor statute, Cal. Civ. Code §34.6. The sentence concerning disaffirmance is identical to the California statuce. One writer[67] who has analyzed the California statute finds that the use of this language has the effect of making the minor financially liable and really has nothing to do with consent. Among the other reasons he gives for this interpretation is that the parents are freed from financial liability, which is also the case in the Massachusetts statute, and if the legislature did not make the child liable, there would be no one responsible to pay the doctor for the treatment.

The section provides that parents shall not be liable for the child's expenses notwithstanding section 141. This refers to §141 of the form chapter 123 of M.G.L.A. which was amended in 1970, and so §141 is now M.G.L.A. c. 123 §54. Both M.G.L.A. c. 123 §38 et. seq. and M.G.L.A. c. 112 §12E deal with the problem of drug rehabilitation, and it is interesting to note how they complement each other.[68] M.G.L.A. c. 123 §45 states that "any person" who

believes that he is drug dependent may apply to a facility for admission. It is more than likely that the words "any person" would not apply to a minor who has not obtained parental consent. However, M.G.L.A. c. 112 §12E allows a minor twelve years of age or older to consent to his own treatment for drug dependency. Therefore, if a minor is diagnosed under §12E as being drug dependent, he could probably be treated under c. 123 §45. If he is treated without his parents' consent, his parents shall not be financially liable as provided in §12E, but if the parent does consent, then he becomes liable under c. 123 §54. If it is accurate that a parent is not liable to pay for the care received by a minor who consents to his own care, not very many institutions are going to be anxious to treat such minors. It is certainly to the institution's benefit to work as diligently as it can to get the parents' consent and make them liable. So although c. 112 §12E attempts to enable minors to consent to drug related care, its circularity (a minor cannot consent to be diagnosed until he is diagnosed as drug dependent) and its payment provisions really discourage the medical profession from rendering care.

Another exception to the general consent rule is found in M.G.L.A. c. 123 §10, which allows a sixteen-year-old to apply for admission to a mental institution. But once a minor is admitted, what type of treatment may the institution administer - psychotherapy, drug therapy, electro-shock therapy, lobotomy? There is

one case[69] under the former voluntary commitment statute[70] which held that an individual's signature to the voluntary admission paper was a consent to all treatment as long as there was no indication that the signer was in no condition to sign or that the paper was signed due to a misrepresentation.

The Department of Mental Health has endeavored to answer this question by promulgating regulations. Regulation M.H. 18 (November 1, 1971) states that when a person is admitted to a facility for care and treatment, he shall receive treatment and rehabilitation in accordance with accepted therapeutic practice, including oral, subcutaneous and intramuscular medication when appropriate and when ordered by a physician. Under M.G.L.A. c. 123 §23 a patient can "refuse" electro-shock therapy and "refuse" lobotomy. The implication would seem to be that unless there is a refusal, such treatment may be administered, which is just the opposite of the general consent law which states that no procedure may be done unless there is a consent. However, regulation M.H. 18 states that lobotomy and electroconvulsive treatment shall require a separate consent by the patient. It would still appear that a sixteen-year-old who is admitted to a facility is a patient and could therefore consent to lobotomy and electroconvulsive therapy.

It is interesting to note that under M.G.L.A. c. 123 §32, unlike the drug rehabilitation section, the parents of a minor are liable for expenses incurred in his treatment for mental illness

whether or not they have consented to it. The result of this is that a twelve-year-old is liable for his own treatment when he commits himself for drug rehabilitation, but a sixteen-year-old's parents are liable for treatment when he commits himself for general psychiatric care. There appears to be no reason for this inconsistency in liability.

Finally, as discussed earlier, M.G.L.A. c. 112 §12F exempts doctors from civil liability if they treat a minor in an emergency situation without obtaining parental consent.

With the law standing as it does, one can come up with some interesting anomalies. For example, a twelve-year-old is deemed mature enough to commit himself to drug rehabilitation programs and mature enough to pay for his care in these programs. A twelve-year-old is also deemed mature enough to choose his parents because he cannot be adopted without his consent.[71] A twelve-year-old is deemed sufficiently mature to consent to these very important and far-reaching occurrences but is not old enough to consent to the simplest physical examination.

Another unusual case would involve a fifteen-year-old girl who finds herself to be pregnant but cannot get prenatal care without parental consent. Should some physician provide such care at his own risk, and should he find that she requires a therapeutic abortion - that is, should he find that such a procedure is "necessary to save her life or to prevent serious impairment of her

health, mental or physical..."[72] - such procedure could not be performed without parental consent until her condition was serious enough to come under the emergency treatment statute. When her child was born, there would be a question whether she could consent to the care of the baby. If she could, she would be in the weird position of being able to consent to someone else's medical care but not her own. If she could not consent to the baby's medical care, who could? If she wanted to put the baby up for adoption, would she be able to consent as required by law? M.G.L.A. c. 209 §2 states that the mother of an illegitimate child must consent to its adoption but says nothing about the age of the mother. If the sixteen-year-old mother could consent to the adoption of her child,[73] the situation would be that she may or may not consent to its medical care, may not consent to her prenatal care, cannot consent to her own medical care, but may consent to give her child away. In other words, the only decision she is allowed to make is the most difficult and the most emotional.

We have seen time and again that parental power is derived from the fact that the parent has the duty to support the child and therefore has the right to control the child's actions.[74] In Massachusetts any person over the age of twenty-one must support his destitute parents.[75] Does this mean the child now has complete control over his parents, including the right to consent to their medical care?

The question of who is financially liable for medical care delivered to the minor is difficult. Minors cannot contract for the purchase of goods or services unless they are found to be necessaries.[76] If the goods or services are found to be necessaries, then either the minor or the guardian will be liable on the contract.[77] The definition of a necessary is very flexible and depends on the minor's condition in life, where he lives and what the society around him does.[78] If services or goods are needed for the health or comfort of the child, they may be necessaries.[79] But in order for any goods or services to be necessaries, it must be shown that the parent or guardian is unwilling or unable to provide such goods or services. Or, as the court has said,

> Goods supplied are not necessaries for which the minor is liable if he has a parent or guardian who was able and willing to supply them.[80]

The burden of proof that goods or services are necessaries is on the plaintiff who is attempting to recover on the contract.[81] Thus, in order for a physician to recover for his services on the ground that they come under the necessaries umbrella, he would have to prove that the parents would not have provided the care if they were approached by the child. This is an extremely difficult burden to meet. Furthermore, the minor will only be held liable for the reasonable value of the goods and services rendered and not the contract price.[82] For a doctor to prove the reasonable value of

his services would again be quite difficult. A doctor concerned about getting paid for his services would do well to steer clear of minors.

What becomes apparent after examining the laws relative to a minor's ability to obtain health care is that they are muddled, vague and illogical. The writer believes that the state has the duty to both minors and physicians to at least clarify the law and hopefully to expand it. Courts in other states have recognized the right of the child to receive adequate medical care. In New York a court found that the mother of a fifteen-year-old boy could not prevent him from procuring an operation that would partially correct a facial deformity on the ground that she was a Jehovah's Witness.[83] The facts that make this case more unusual than other cases with this general fact pattern are that the condition could not be cured but only partially corrected, that the condition did not put his life or health in danger, and that inherent in the corrective procedure was a fair amount of risk because the proposed surgery would take six to eight hours. The New York court cited an Ohio case which states,[84]

> The child is a human being in his own right, with a soul and a body of his own. He has rights of his own - the right to live and grow up without disfigurement.... The child is a citizen of the state. While he "belongs" to his parents, he likewise belongs to the state. Their rights in him entail many duties. Likewise, the fact the child belongs to the state imposes upon the state many duties. Chief among them is to protect his right to live and grow up with a sound mind and a sound body....

In Massachusetts the policy of the Commonwealth is set out in M.G.L.A. c. 119 §1, in which it is stated that the primary policy is to strengthen the family for the protection and care of children. It is also the policy "to insure the rights of any child to sound health and normal physical, mental, spiritual and moral development" (emphasis added). The purpose of c. 119 is "to insure that the children of the Commonwealth are protected against the harmful effects resulting from the absence, inability, [and] inadequacy..." of parents in providing care for their children. So the Commonwealth at least recognizes that there are times the family cannot provide care for the child. This disability should not only be seen in financial terms, or in the cases when there is a complete family breakdown, but should also be seen in the case when a daughter cannot tell her parents that she is pregnant. This is a case when the family cannot provide care for the child.

A change in the law would merely say that when an adolescent, for one reason or another, cannot go to his parents for help, he can still go to a doctor and receive medical care. This does not lead to the result of no child ever going to his parents for help. The parent-child relationship is not based on law. When a parent asks a child to perform some task, the child does not do it because the common law says he must. He does it for a number of complex reasons ranging from love and devotion to fear. When a child confides in a parent, it is not because the law says he must. It

would be a sad commentary on the American family if it is contended that all family interaction is a result of the coercive power of the law. Because the family is more than a creature of the law, a change in the laws concerning medical care to minors will not bring on the collapse of the family. What would happen is that children who are in families that are already broken down, and children in families that are basically sound but cannot deal with a specific situation, will be able to acquire help on their own. A new law would not require children to ignore their parents; it would only help children already alienated from their parents.

If a law is written for which a specific age of consent must be chosen, the age should not be drawn from a hat, but should be arrived at rationally with the help of specialists in fields of child development and adolescent care. For example, in the field of criminal law, one finds various chronological ages listed for the age of responsibility. One writer on the subject has suggested that since research has been done by psychologists showing there is a culturally universal age when the development of a sense of justice occurs, this should determine the age of responsibility.[85] It is this type of analysis that should be utilized when choosing an age of consent.

Instead of listing an age, a statute may provide for other objective requirements such as a highschool education, living apart from one's parents, marriage of a whole range of other situations.

The problem one encounters by utilizing this method is that the enumeration of these requirements can be just as arbitrary as deciding on an age. What makes a pregnant fifteen-year-old or a married fifteen-year-old any more able to consent to medical care than an unmarried or "unpregnant" fifteen-year-old?

Another method of writing a statute might be to create a list of diseases or conditions for which a minor may be treated without parental consent.

Or one can combine several of these methods as did Mississippi.[86] Mississippi has performed the admirable task of compiling all the law pertaining to medical care and putting it all in one place in its code. Thus, it has a list of people who may consent to medical treatment. Among them one finds an adult, for himself; a parent, whether an adult or minor, for his minor child; any married person; any adult, for his parent of unsound mind; an emancipated minor; "any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures"; any woman, regardless of age, when given in connection with pregnancy; any adult, for his brother or sister of unsound mind.

The idea of codifying and locating all laws concerned with medical care in one place is extremely sound, as it enables the doctor to determine what he can and cannot do without requiring the services of a lawyer. The section of the Mississippi statute

which allows an unemancipated minor of sufficient intelligence to consent to medical care does not have the precision one might hope for, but it gives the doctor and the patient great leeway for them to decide what can and cannot be done. It does away with the concept of a magical age when one knows everything. It enables the doctor to treat the mature fifteen-year-old and not to treat the immature twenty-year-old.

The problem with the Mississippi statute, as well as with most of the statutes of the other states is that it is silent on the point of financial responsibility for care received. The statute should deal with this issue squarely so all parties will know where they stand. The language should stay away from the word "disaffirmance" and should merely state that minors are responsible for paying all costs of medical care to which they consent on their own, if this is the result the legislature finds to be desirable.

Finally, there should be a section concerning confidentiality, so that a doctor could not inform a minor's parents that he was being treated for a certain condition. If a minor wants his parents to know he is being treated, he will tell them. However, care must be taken so that parents could acquire the records if the child became comatose or died and the records were needed to bring an action against the doctor.

It is beyond question that a new statute is needed in Massachusetts. The law should not remain the law merely because it has

always been that way. As Justice Holmes once wrote,

> It is revolting to have no better reason for a rule of law than that it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past.[88]

NOTES

[1] Prosser, Law of Torts 36 (4th ed. 1971).

[2] Id. at 35. See also, Cardozo in Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914) - "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault for which he is liable in damages."

[3] Id. at 36.

[4] 49 S.W. 775, 20 Ky. L. Rptr. 1567 (1899).

[5] Pilpel, Minors' Right to Medical Care, 36 Albany L. Rev. 462, 463; Wiss, Position Paper - Medical Care and the Minor (unpublished paper delivered to the Conference on the Rights of Minors) Oct. 22, 1971.

[6] For an interesting discussion of how society perceives the adolescent, which includes the perception of the adolescent as victim, see, Anthony, The Reaction of Parents to Adolescents and to their Behavior, In, Parenthood: Its Psychology and Psychopathology 307 (E.J. Anthony, M.D. and T. Benedek, M.D. eds. 1970). The author discusses the adolescent as perceived as a victim - "passive and powerless in the face of adult corruption that seeks to exploit his gullibility." Id. at 309.

[7] 126 F.2d 121 (D.C. Cir. 1941); Annot. 139 A.L.R. 1370 (1941).

[8] 139 A.L.R. 1367, 1368.

[9] 1 W. Blackstone, Commentaries* 464.

[10] The Inhabitants of Danvers v. The City of Boston, 27 Mass. 512 (1830); Bardwell v. Purrington, 107 Mass. 419, 425 (1871); Babtkus v. Jutras, 31 Mass. App. Dec. 98 (1964); W. Blackstone, supra at * 463.

[11] See, e.g., Note, Infants' Contractual Disabilities: Do Modern Sociological and Economic Trends Demand a Change in the Law?, 41 Ind. L.J. 140 (1965-66); Edge, Voidability of Minors' Contracts; A Feudal Doctrine in a Modern Economy, 1 Ga. L. Rev. 205 (1966-67).

[12] Elements of Roman Law by Gaius, § 189 (E. Poste transl. 1890).

[13] Id. at § 196.

[14] Id. at § 55. See also, James, The Age of Majority, 4 Am. J. of Legal Hist. 22, 24 (1960). He discusses three age groups at the time of Justinian. 1) Infantia - the period during which the child was incapable of speech. About 407 A.D. this was determined to be seven years of age. 2) "Tutela impuheres" - which ended at puberty when a tutor was no longer required and when the child could have children. This was set at fourteen for males and twelve for females. 3) "Cura minoris" - at the age of twenty-five, when a citizen reached full adulthood.

[15] Id. at 23.

[16] Id. at 27.

[17] Id. at 25.

[18] Id. at 22.

[19] Id. at 24.

[20] Tyler, Law of Infancy and Coverture, 34 (1868).

[21] Edge, supra note 11, at 220.

[22] Id. at 221, 222.

[23] W. Blackstone, supra note 9 at * 463.

[24] M.G.L.A. c. 175 § 128.

[25] M.G.L.A. c. 90 § 8.

[26] M.G.L.A. c. 207 § 10. The age of consent for males was lowered from 21 to 18 by Acts 1971, Ch. 225 § 1.

[27] M.G.L.A. c. 123 § 10.

[28] 166 Ohio St. 40, 139 N.E. 2d 25, 30 (1956).

[29] See, e.g., Kleinfield, The Balance of Power Among Infants, Their Parents and the State, 4 Family Law Quarterly 410, 413.

[30] 144 Mich. 632, 108 N.W. 94 (1906).

[31] Pilpel, supra note 5 at 466.

[32] Lacey v. Laird, supra note 28.

[33] Bakker v. Welsh, supra note 30.

[34] Moss v. Rishworth, 222 S.W. 225 (Texas, 1920).

[35] 2 Williston on Contracts § 224 at 3.

[36] 31 Mass. App. Dec. 98 (1964).

[37] Frye v. Yasi, 327 Mass. 724 (1951).

[38] Edge, supra note 11 at 208.

[39] Lacey v. Laird, supra note 28, 139 N.E. 2d at 34.

[40] 233 Ore. 1, 376 P. 2d 406 (1962).

[41] 152 Ohio St. 463, 90 N.E. 2d 142 (1950).

[42] 164 Ohio St. 41, 128 N.E. 2d 80 (1955).

[43] 341 Mass. 531 (1960).

[44] 65A C.J.S. 287.

[45] 5A Miss. Code Ann. § 7129-81(H) (1971 Supp. L.).

[46] Pilpel, supra note 5 at 465.

[47] 15 Mass. 272 (1818).

[48] Id. at 275.

[49] Id. at 203.

[50] The right to receive relief under the poor laws of a town, acquired by living in the town for a prescribed period of time.

[51] 157 Mass. 73 (1892).

[52] Sherburne v. Hartland, 37 Vt. 528, 529 (1865).

[53] Corbridge v. Corbridge, 230 Ind. 201, 102 N.E. 2d 764 (1952).

[54] 431 P. 2d 719 (Wash. 1967).

[55] For an excellent examination of the California statute, see. Note, Medical Care and the Independent Minor, 10 Santa Clara Lawyer 336 (1970).

[56] For an explanation of the rule and applicable cases, see, 76 A.L.R. 566 and 139 A.L.R. 1379.

[57] M.G.L.A. c. 112 § 12F.

[58] 61 P. 2d 1019 (Okl. 1936).

[59] Mass. Physician, Jan. 1966 at 94.

[60] Informed Consent in Medical Malpractice, 55 Cal. L. Rev. 1397 (1967).

[61] Note, Restructuring Informed Consent: Legal Therapy for the Doctor, 79 Yale L.J. 1533 (1970).

[62] Karchmer, Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug," 31 Mo. L. Rev. 28 (1966).

[63] Supra Note 61 at 1546.

[64] Ballard v. Anderson, 4 Cal. 3d 837, 95 Cal. Rptr. 1, 484 P. 2d 1345 (1971). The case states that in medical emancipation statutes there is an implied limitation that a minor is mature enough to give informed consent.

[65] Masden v. Harrison, 68651 Eq. Mass. Sup. Jud. Ct. June 12, 1957; Huskey v. Harrison, 68666 Eq. Mass Sup. Jud. Ct. Aug. 30, 1957; Fostor v. Harrison, 68674 Eq. Mass. Sup. Jud. Ct. Nov. 20, 1957.

[66] M.G.L.A. c. 112 § 2.

[67] Supra, Note 55 at 341.

[68] It is interesting to note that § 12E was approved August 27, 1970 and § 38 et. seq. were approved Sept. 1, 1970.

[69] Belger v. Arnot, 344 Mass. 679, 686 (1962).

[70] M.G.L.A. c. 123 § 86 (1955).

[71] M.G.L.A. c. 210 § 2.

[72] Com. v. Wheeler, 315 Mass. 394, 395 (1944).

[73] We were told by an attorney for the Department of Public Welfare that sixteen-year-old girls do consent to adoption and that none, to his knowledge, has tried to revoke consent on the ground of minority.

[74] Lacey v. Laird, supra Note 28; Kleinfield, supra Note 29.

[75] M.G.L.A. c. 273 § 20.

[76] Williston on Contracts § 240.

[77] Moskow v. Marshall, 271 Mass. 302 (1930); L.P. Hollander Co. v. Porter, 267 Mass. 380, (1929); Auringer v. Cochrane, 225 Mass. 273 (1916).

[78] See, 15 The Legalite 506 et. seq.

[79] Auringer v. Cochrane, supra Note 77 at 274: Williston on Contracts § 241.

[80] L.P. Hollander Co. v. Porter, supra Note 77 at 380: Moskow v. Marshall, supra Note 77 at 306.

[81] L.P. Hollander Co. v. Porter, supra Note 77 at 380. Moskow v. Marshall, supra Note 77 at 306.

[82] Trainer v. Trumbull, 141 Mass. 527, 530 (1886).

[83] In the Matter of Sampson, 317 N.Y.S. 2d 641 (1970).

[84] In Re Clark, 21 Ohio Op. 2d 68, 185 N.E. 2d 641 (1970).

[85] Côte-Harper, Age, Delinquent Responsibility and Moral Judgment, 11 Les Cahier de Droit 489 (1970).

[86] Miss. Code Ann. § 7129-81 (1971 Suppl.).

[87] Cal. Civ. Code § 34.6.

[88] Holmes, The Path of the Law, 10 Harv. L. Rev. 457, 469 (1897).